No. 4773 P. 3.
PRINTED: 00/07/2018
FORM APPROVED

Division	of Health Care Faci	lities				
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A BUILDING: 01 - MAIN BUILDING 01		COMPLETED		
					R	
		TN9505	e, WING		06/05/2018	
				TATE THE COLE		
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
QUALITY	CENTER FOR REHA	BU ITATION AND	OUR PARK 1, TN 3708 7			
	ATS VOAMMILS	TEMENT OF DEFICIENCIES	ID	ION (XE)		
(X4) ID PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU	ILD BE COMPLE	ETE
1AG	REGULATORY OR L	REGULATORY OR LSC IDENTIFYING INFORMATION)		CROSS-REFERENCED TO THE APPRO DEFICIENCY)	PRIATE DATE	-
				CO CONTRACTOR CONTRACT		
(N 831)	1200-8-608 (1) Bu	Illding Standards	{N 831}			
SS=D		many quantum				
		shall construct, arrange, and	91			
		on of the physical plant and				- 1
		home environment in such a				
	manner that the sat	fety and well-being of the			(a)	
	residents are assur		1			
					-	
				W .	1.1.	1.2
		Î		N831 -1200-8-6-,08 (1) Bullding 5	tandards 600	118
	771 / D. J		_	2	(I I)	
	This Rule is not met as evidenced by: Based on observations, the facility failed to			1. Corrective Action: The improper		
	Based on observati	ons, the racility railed to		in the cross corridor behind the o office (office side) and patient sid		
	maintain the physic	ai piant and overail		removed by fire stop system cons		
	environment.			and replaced according to the ap		4
	The findings include	ad,	system utilized, ADM and/or N			
	The lindings included.			Educator inserviced the outside	1	
	1. Observations on	4/30/2018 between 11:12 AM		contractors performing a remode		
		d unsealed penetrations to the	į	currently in the facility to ensure		
		above the ceiling in the		any penetrations they make appr	20	4
	following locations:	_		Director of Maintenance inservic	. 1	
		itside room 29-1 sleeve		ensure fire stop systems.are appl according to the specifications of		
		colored cables unsealed at	-	system. ADM or designee educat	ted	
33	the wall and unseal			maintenance staff how to identif	v the	
	2. Cross corridor of	itside room 39 (on both sides		appropriate fire penetration syst	11: 00:	
		e containing multiple colored		required to seal any penetrations		
		the wall and unsealed on the		2. Identifying other residents with		
	end	ehind the old admin office:	į	to be affected: The facility deter		
) i		nsealed at the deck, 1 sleeve		residents near the affected areas	have the	
		nsealed, between 2 flex		potential to be affected. 3 Measures or Systemic Changes:	The	
		ealed penetration around it:		3. Measures or Systemic Changes: Maintenance Director or designe		
		w voltage wires unsealed, 1		audit the areas the outside contr	1/4	
		n the end and at the wall,	1.5	works on dally for 4 weeks and the		
	unsealed at the dec	ck.		weekly for 2 months to ensure th		
		ıtside room 74- unsealed		leave any penetrations they may		
	conduit above the c			unsealed. Outside contractor ed		
		itside room 72- sprinkler line		performing a remodel currently i	n the	
		le NFPA 101, 8.3.5.1 (2012		facility to ensure they seal any	lately	
	Edition)	9 2007		penetrations they make appropr	lavely.	4.00
Division of Health Care Facilities (X6) DATE						

LABORATORY DIRECTOR'S OF PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Administrator

F. 4
PRINTED: U6/07/2018
FORM APPROVED

Division of Health Care Facilities							
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF GORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 - MAIN BUILDING 01		X3) DATE SURVEY COMPLETED			
MAD I DIN OI GONTESTION		A, dolloine	A, BUILDING: 01 - WAIN BUILDING 01				
TN9506		B, WING	B. WING				
NAME OF I	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE						
CHALITY	CENTER FOR REHA	PILITATION AND	DOUR PARK				
QUALITY		LEBANO	N, TN 37087		ON WE		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTIVE ACTION SHOUL (EACH CORRECTIVE ACTION SHOUL) TAG CROSS-REFERENCED TO THE APPROIDEFICIENCY)			LD BE COMPLETE			
{N 831}	- 11:23 AM, revealer following locations: 1. Cross corridor be (office side)- Foam voltage cable, penemud. NFPA 101, 8. **On a revisit on 6/firestop systems prand the head of was been installed per lon the PT floor side Edition) This finding was versitions:	4/30/2018 between 11:12 AM d improper fire caulk in the shind the old admin office in penetration around low strations sealed with sheetrock 3.5.1 (2012 Edition) 5/2018 at 3:45 PM, revealed ovided had not been followed all system fire stop had not JL system above the fire doors in NFPA 101, 8.3.5.1 (2012) rified and acknowledged by the maintenance director		4. How corrective action will be more The ADM or designee will review a reports from the Maintenance Direction designee at Stand Up meetings to determine if any violations or conceiver identified. The ADM or designee an audit form to docume findings of reviews weekly for 4-withen monthly for 2 months. The Adesignee will review the audits and findings to the QAPI committee. To committee will review the results QAPI meeting to ensure the POC weffective and if any further correct action is warranted.	ector, or lector, or l		
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Division of Health Care Facilities

No. 4309 F. 49/50 PRINTED: 05/03/2018 FORM APPROVED

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 - MAIN BUILDING 01 (X3) DATE SURVEY COMPLETED					
		TN9505	B. WING	04	/30/2018		
	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 932 BADDOUR PARKWAY LEBANON, TN 37087						
(X4) ID PREFIX TAG	(X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE		
N 831 SS=D	(1) A nursing home maintain the conditi the overall nursing l	shall construct, arrange, and on of the physical plant and nome environment in such a left and welf-being of the	N 831				
	This Rule is not me Based on observati maintain the physic environment. The findings include	o⊓s, the facility failed to al plant and overall	70 TO	N831 -1200-8-6-08 (1) Building Standards Corrective Action: The unsealed penetrations to the 1 hour fire barriers above the celling at the cross corridor outside room 29, cross corridor outside room 39, cross corridor behind old adm office, cross corridor outside room 74, cross corridor outside room 72 were sealed and the fire caulk at cross corridor	5/23/18		
	- 11:23 AM revealed 1 hour fire barriers of following locations: 1. Cross corridor outcontaining multiple the wall and unseal 2. Cross corridor out of the wall)- 1 sleev cables unsealed at end 3. Cross corridor be	triside room 39 (on both sides e containing multiple colored the wall and unsealed on the whind the old admin office;		behind the old admin office was replaced with appropriate seal. ADM and/or Nurse Educator inserviced the outside contractors performing a remodel currently in the facility to ensure they seal any penetrations they make appropriately ADM or designee educated maintenance staff how to identify the appropriate fire penetration system required to seal any penetrations. Identifying other residents with potentia to be affected: The facility determined residents near the affected areas have the			
	(with a red cable) un conduits, 1 flex uns B. Admin side- 2 low conduit unsealed or unsealed at the dec 4. Cross corridor of conduit above the d 5. Cross corridor of	tside room 74- unsealed		potential to be affected. Measures or Systemic Changes: The Maintenance Director or designee will audit the areas the outside contractor works on daily for 4 weeks and then weekly for 2 months to ensure they do no leave any penetrations they may make unsealed. Outside contractor educated performing a remodel currently in the facility to ensure they seal any penetrations they make appropriately.			
ivision of He	ealth Care Facilities	FR/SUPPLIER REPRESENTATIVE'S SIG	NATURE .	TITLE	(X6) DATE		

Administrator

No. 4309 P. 50/50

PRINTED: 05/03/2018 FORM APPROVED

Division	of Health Care Faci	lities		1.1.2	, , , ,	
STATEMEN	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
ANDFUAN	ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A, BUILDING: 01 - MAIN BUILDING 01			
	H	TN9505	B. WING		04/30/2018	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
QUALITY CENTER FOR REHABILITATION AND 932 BADDOUR PARKWAY LEBANON, TN 37087						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COMP CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
N 831	Continued From page 1 2. Observations on 4/30/2018 between 11:12 AM - 11:23 AM, revealed improper fire caulk in the following locations: 1. Cross corridor behind the old admin office (office side)- Foam in penetration around low voltage cable, penetrations sealed with sheetrock mud. NFPA 101, 8.3.5.1 (2012 Edition)		N 631	How corrective action will be monitored: The ADM or designee will review audit reports from the Maintenance Director or designee at Stand Up meetings to determine if any violations or concerns were identified. The ADM or designee will complete an audit form to document findings of reviews weekly for 4 weeks then monthly for 2 months. The ADM or designee will review the audits and report findings to the QAPI committee. The QAPI committee will review the results at the QAPI meeting to ensure the POC was effective and if any further corrective action is warranted.		
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